Assisted Living Facility Type I - Resident Assessment

Resident Name:_____ Date of Birth:_____

Date of Admission:_____

Medication Assessment:

Medication Name:	Dosage:	Route:	Frequency by time

Level of Medication Assistance Needed:

____ **Self-Administer**: Requires no assistance or supervision, may keep under own control in own room. Locked container may be needed for safety.

____ **Self-Direct Medication Administration**: Resident can recognize medications offered by color or shape; and question differences in the usual routine of medications.
Assistance Needed:
- ____ Reminder to take
- ____ Opening container
- ____ Remind resident/responsible person when prescription needs to be refilled.

____ **Family/Designated Person Administer**: Medication prepared by licensed practitioner or licensed pharmacist. Same person responsible to document administration.

____ **Significant (Total) Assist**: Facility staff administer medications as delegated by a licensed health care professional according to Service Plan.

Comment:_____

_____

Known Medication Allergies:_____

_____

Person who will provide medications for resident:
Name:_____

Address:_____ Telephone: _____

Physical Assessment

Medical/Surgical History:_____

_____

_____

Vital signs: Temperature:_____ Pulse:_____ Respiration:_____ B/P:_____ Weight:_____

Review of Systems: (Refer to Assessment Guidelines, Page 3)

Integumentary: _____

_____

_____

Respiratory: _____

_____

_____

Cardiovascular: _____

_____

_____

Gastrointestinal : _____

_____

_____

Genitourinary: _____

_____

_____

Musculoskeletal: _____

_____

_____

Neurological: _____

_____

_____

Endocrine: _____

_____

_____

Pain: _____

_____

_____

ASSESSMENT GUIDELINES

Integumentary System - assessment will include skin color, skin temperature, skin integrity, turgor and condition of mucous membranes.

Normal findings: skin color good/within norm; skin warm/dry/intact; no skin problems; mucous membranes moist/pink.

Respiratory System - assessment will include quality/characteristics of respiration; lung/breath sounds; cough/sputum; color of nail beds/mucous membranes.

Normal findings: respirations quiet/easy/regular; RR 10-20/minute at rest; breath sounds vesicular through both lung fields; bronchial over major airways with no adventitious sounds; no cough; sputum clear; nail beds and mucous membranes pink; no other respiratory problems.

Cardiovascular System - assessment will include peripheral pulses/apical pulse; chest pain; edema; calf tenderness; cardiac rhythm/sound.

Normal findings: peripheral pulses palpable, resent and strong; regular apical pulse; no chest pain; neck vein flat/no distention; no edema; no calf tenderness; S1 and S2 audible and regular; no other cardiac problems.

Gastrointestinal System - assessment will include appearance/palpation of abdomen; bowel sounds; bowel pattern/stools; appetite; diet tolerance; fluid intake; weight; nausea and vomiting.

Normal findings: abdomen soft; bowel sounds present and active; no pain on palpation; fair to good appetite; tolerates diet without nausea and vomiting; adequate fluid intake; no weight loss or gain; normal bowel movement, pattern and consistency.

Genitourinary System **-** assessment will include voiding pattern; urine characteristics; bladder distention; prostate problems; menstrual pattern; breast mass/pain.

Normal findings: able to empty bladder without difficulty or pain; bladder not distended; urine clear/yellow to abler; no prostate problem; no menstrual problems; no breast mass or pain.

Musculoskeletal System - assessment will include joint swelling, tenderness, ROM limitations, muscle strength and condition of surrounding tissue.

Normal findings: absence of joint swelling and tenderness, normal ROM on all joints; no muscle weakness; no ADL problems; no activity or functional limitations; no evidence of inflammation, nodules, ulcerations or rashes.

Neurological System - assessment will include orientation, pupils, movement/gait, sensation, quality of speech/swallowing and memory, sleep pattern, seizures, vision, hearing.

Normal findings: alert and oriented to person, place, and time; PERL; active ROM of all extremities with symmetry of strength; no paresthesia; no seizures; verbalization clear and understandable, memory intact; normal gait; normal swallowing/gag reflex; regular sleep pattern; no visual or hearing impairment.

Endocrine System - assessment will include presence of diabetes, thyroid problems and other endocrine dysfunctions.

Normal findings: Absence of thyroid or endocrine problems or dysfunctions; **no diabetes**.

Pain Assessment - will include presence of pain; the resident's description, location, duration, intensity, radiation, precipitating factors and alleviating factors.

Normal findings: Document if medication relieves pain.

Activities of Daily Living Assessment

Assessment of the resident's ability or present condition in the following:

1. Memory: (Narrative)

2. Capability in making daily decisions:
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

3. Ability to communicate effectively with others (Narrative)
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

4. Physical functioning and Ability to perform Activities of Daily Living (ADL)

a. Personal Grooming and Dressing
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

b. Oral Hygiene/Denture Care
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

c. Dressing
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

d. Toileting, Toilet Hygiene
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

e. Bathing:
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

f. Eating at mealtime
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

g. Ambulation or Mobility
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

5. Continence
Continent of Bowel & Bladder:__ Continent of Bowel only:___ Continent of Bladder only:___
Independent:___ *Semi-Independent/Limited Assist:___ Significant (Total) Assist:___
*Describe:

6. Mood and behavior patterns (Narrative)

7. Weight loss
Ideal Body Weight:___ Present Weight:___

8. Medication use and ability to self-medicate
Self-administer:___ Semi-Independent/Limited Assist:___
Family/Designated Person Administer:___ Significant (Total) Assist/Facility Staff Administer:__
*Describe:

9. Special treatments and procedures: (Narrative)

10. Disease diagnosis with relationship to current ADL status, Behavior status, Medical Treatments or Risk of death: (Narrative)

11. Assistive devices and assistance needed to promote independence e.g., crutches, braces, walkers, wheelchairs, canes, etc.: (Narrative)

12. Prosthetics devices used and assistance needed e.g., glasses, dentures, hearing aids: (Narrative)

13. Assess **Dietary Needs** e.g., food allergies, preferences, and dislikes:

14. Specific assistance needs, include frequency and times.
Housekeeping:

Maintain independence and sense of self-direction:

Ambulation:

Transferring:

Communication:

Managing personal resources:

Scheduling appointments:

Activity and Leisure Needs Assessment

Residents will be encouraged to maintain and develop their fullest potential for independent living through participation in activity and recreational programs.
Current interests:

Past interests:

Resident needs:

Notes/Comments:

Assess needed physician and or other appointments (laboratory work, therapy, etc.) and the person responsible to schedule and transport.

Name:_____ Phone:_____

Address:_____
Assess outside health care providers e.g., independent health care professional and/or home health agency. Identify service(s) and provider(s) with name and phone number.

Name:_____ Phone:_____

Address:_____

Identify:
Physician:_____ Phone:_____

Address:_____

Dentist:_____ Phone:_____

Address:_____

Family Contact Person(s)
Name:_____ Phone:_____

Address:_____

Name:_____ Phone:_____

Address:_____

Name:_____ Phone:_____

Address:_____

Notes:

Assisted Living Facilities, Type I, are intended to enable persons experiencing functional impairment to receive 24-hour personal care and health-related services in a place of residence with sufficient structure to meet their care needs in a safe manner.

Residents are provided limited assistance with Activities of Daily Living, and social care in a residential setting.

Residents must be: ambulatory or mobile, and capable of exiting the facility in an emergency without the assistance of another person; in stable health; and require limited assistance with Activities of Daily Living.

Residents who require significant (total) assistance from staff or others with two (2) or less Activities of Daily Living, may be admitted providing the staffing level and coordinated supportive health and social services can meet the needs of the resident. Residents may receive regular or intermittent health care services from a licensed health care professional.

Residents who manifest behavior: that is assaultive, threatening or dangerous to themselves or others; that is sexually or socially inappropriate; or who have Tuberculosis or other chronic communicable disease that is unable to be safely treated in the facility or on an outpatient basis; or, who require inpatient care in a hospital or long-term nursing care; or who require significant assistance during night sleeping hours are not eligible for admission.

An Assisted Living Facility, Type 1, initial assessment must be completed by a physician, advanced practice registered nurse, physician assistant, or a registered nurse prior to admission.

To the best of my knowledge this resident meets the above admission criteria for an Assisted Living Type 1 facility.

Signature:_____ Title: _____ Date: _____

Printed Name:_____